MISSOURI VETERANS COMMISSION
MISSOURI VETERANS HOME

ADMISSION MEDICAL INFORMATION

☐ CAMERON ☐ ST. JAMES
☐ CAPE GIRARDEAU ☐ ST. LOUIS
☐ MEXICO ☐ WARRENSBURG
☐ MT. VERNON

NAME		DATE
INDIVIDUAL PROVIDING INFORMATION	RELATIONSHIP TO RESIDENT	TELEPHONE

SELF-CARE STATUS (CHECK LEVEL OF ASSISTANCE NEEDED)

	NO HELP NEEDED	NEEDS SUPERVISION	A LITTLE ASSISTANCE	A LOT OF ASSISTANCE	TOTAL ASSISTANCE
Can the applicant feed him/herself?					
Can the applicant dress him/herself?					
Can the applicant bathe him/herself?					
Can the applicant transfer him/herself?					
Does the applicant walk?					

SELF-CARE STATUS (CHECK APPROPRIATE ANSWER)

		YES	NO
EATING	Any difficulty chewing or swallowing?	☐	☐
	IF YES, DESCRIBE		
	In the last 3 months, has there been a decline in the ability to feed self?	☐	☐
	COMMENTS		
	PLEASE LIST SPECIAL DIET ORDERS		
	PLEASE LIST ANY FOOD ALLERGIES		
WEIGHT	Any changes in weight in past month?	☐	☐
	Any changes in weight in past 6 months?	☐	☐
	IF YES, DESCRIBE		
	USUAL ADULT BODY WEIGHT (AVERAGE WEIGHT OVER PAST 2 YEARS)		
DRESSING	In the last 3 months, has there been a decline in the ability to dress self?	☐	☐
	COMMENTS		
WALKING	Does the applicant need assistance? If so, how much?	☐	☐
	Does the applicant use any of the following (check one): ☐ cane, ☐ walker, ☐ wheelchair, ☐ gerichair?	☐	☐
	In the past month, has the applicant fallen?	☐	☐
	In the past 6 months, has the applicant fallen?	☐	☐
	COMMENTS		
BOWEL/BLADDER	Is the applicant able to control bladder?	☐	☐
	Does the applicant use a urinary catheter?	☐	☐
	Does the applicant have a history of urinary tract infections?	☐	☐
	Has the applicant been hospitalized or treated for urinary tract infections in the past 6 months?	☐	☐
	IF YES, WHEN?		
	In the past 3 months, has there been a decline in ability to control bladder?	☐	☐
	Is the applicant able to control bowels?	☐	☐
	Does the applicant have a history of constipation?	☐	☐
MENTAL	Is the applicant confused?	☐	☐
	Does the applicant wander?	☐	☐
	Is the applicant combative?	☐	☐
	In the past 3 months, has there been a decline in memory and/or decision making?	☐	☐
	COMMENTS		
	Any sleeping problems?	☐	☐
	IF YES, DESCRIBE		
	In the past 3 months, has there been a decline in mood and/or behavior?	☐	☐
	IF YES, DESCRIBE		

SELF-CARE STATUS (CHECK APPROPRIATE ANSWER)		YES	NO
COMMUNICATION ABILITY	Can speak	☐	☐
	Can write	☐	☐
	Understands speaking	☐	☐
	Understands writing	☐	☐
	Understands gestures	☐	☐
	Understands English	☐	☐
	If no, state language spoken:		
	Does the applicant have any difficulties with speech?	☐	☐
	Does the applicant have any difficulties with hearing?	☐	☐
	Does the applicant have any difficulties with eyesight?	☐	☐
	In the past 3 months, has there been a decline in ability to express him/herself, understand or hear?	☐	☐
	COMMENTS		
Does the applicant have any skin breakdowns or bed sores?		☐	☐
OXYGEN	Does the applicant use oxygen?	☐	☐
	IF YES, DESCRIBE HOW OFTEN?		
	HOW MANY LITERS OF OXYGEN NEEDED?		
	Any respiratory treatments?	☐	☐
	IF YES, DESCRIBE		
Does the applicant have pain daily?		☐	☐
IF YES, DESCRIBE PAIN AND TREATMENTS			
Has there been any new diagnosis since the initial application?		☐	☐
IF YES, DESCRIBE			
In the past 3 months, has the applicant been hospitalized?		☐	☐
IF YES, WHERE			
In the past 3 months, has the applicant been seen in the ER?		☐	☐
IF YES, WHERE			
Any visits to psychologist, psychiatrist, or social worker?		☐	☐
IF YES, SEEN BY WHOM, WHEN, WHERE?			
HISTORY	**Resident history 5 years prior to entry**	☐	☐
	Prior stay at this nursing home?	☐	☐
	Stay in other nursing home?	☐	☐
	Other residential facility (board and care home, assisted living, group home, etc.)	☐	☐
	Mental health/psychiatric setting?	☐	☐
	Mentally retarded/developmentally disabled?	☐	☐
	None of the above	☐	☐

In the year prior to date of entry to this nursing home, or year last in community if now being admitted from another nursing home, does the applicant (check appropriate answer):

CYCLE OF DAILY EVENTS	YES	NO
Stay up late at night (after 9 p.m.)?	☐	☐
Nap regularly during day (at least 1 hour)?	☐	☐
Go out 1 or more days a week?	☐	☐
Stay busy with hobbies, reading or fixed daily routine?	☐	☐
Spend most of time alone or watching TV?	☐	☐
Move independently indoors (with assistive devices, if used)?	☐	☐
Use tobacco products, at least daily?	☐	☐

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EATING PATTERNS	YES	NO
Distinct food preference?	☐	☐
Eats between meals?	☐	☐
Uses alcoholic beverages at least weekly?	☐	☐
ACTIVITIES OF DAILY LIVING	**YES**	**NO**
In bedclothes much of the day?	☐	☐
Wakens to toilet all or most nights?	☐	☐
Has irregular bowel movement pattern?	☐	☐
Prefers showers for bathing?	☐	☐
Bathe in the p.m.?	☐	☐
Bathe in the a.m.?	☐	☐
INVOLVEMENT PATTERNS	**YES**	**NO**
Daily contact with relatives/close friends?	☐	☐
Usually attends church, temple, synagogue, etc.?	☐	☐
Finds strength in faith?	☐	☐
Daily animal companion/presence?	☐	☐
Involved in group activities?	☐	☐

IS THERE ANY OTHER INFORMATION CONCERNING THE APPLICANT THAT WOULD BE HELPFUL?

NAME OF APPLICANT

SIGNATURE

DATE